



SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Addressing Substance Use and the Opioid Epidemic in Integrated Care Settings

2018 PBHCI Regional Meeting

Disclaimer:

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Setting the Stage for the Day

- Overdose deaths are increasing at an alarming rate.*
- Alcohol-related deaths on the rise (35 year high).*
- Tobacco use is the leading preventable cause of death and disease in the United States.*

[NCHS Data Brief No. 294, December 2017](#)

[CDC](#)

https://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/coverage.pdf

The day's presentations and activities are designed to help grantees think through how they can better address SUDs in their respective programs.

ATTC and consultant have been identified to provide information and helpful resources for grantees.

Agenda for the Day

8:30 – 8:45 am

Welcome/Recap of Day One

8:45 – 9:00 am

Setting the Stage for the Day

9:00 – 10:00 am

State of Substance Use

10:00 – 10:15 am

Stretch Break

10:15 – 11:00 am

Roundtable Discussion

11:00 – 11:45 am

Team Time: Workplan Development

11:45 – 12:00 pm

Wrap Up & Evaluation

12:00 pm

Adjourn

PBHCI Grant Requirement (Cohorts 8-9)

When developing an integrated treatment team, grantees must include the following members at minimum:

- Primary care provider
- Nurse care coordinator
- Integrated care manager
- Peer wellness coach
- **Co-occurring/substance use disorder counselor**
- Other: pharmacist, nutritionist/dietician, dentist, occupational therapist, etc.



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SAMHSA Primary and Behavioral Health Care Integration Central Regional Meeting

The State of Substance Use Disorder Treatment Nationally and Regionally

March 8-9

Denver Federal Building



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Presentation Outline

- **Overview of the ATTC Network**
- **State of substance use disorders regionally and nationally**
- **Relevance of integration to addressing opioids/substance use**
- **Prevention and treatment options**
- **Development of Community partnerships to address substance use**
- **Local and Federal resources**



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2017-2022 Addiction Technology Transfer Center (ATTC) Network



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The 2017-2022 ATTC Network is comprised of:

1 Network Coordinating Office

10 Domestic Regional Centers

1 National American Indian and Alaska Native ATTC

6 International HIV Centers (PEPFAR funded)



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Domestic ATTCs' Mission

Established in 1993 by SAMHSA, the domestic ATTCs:

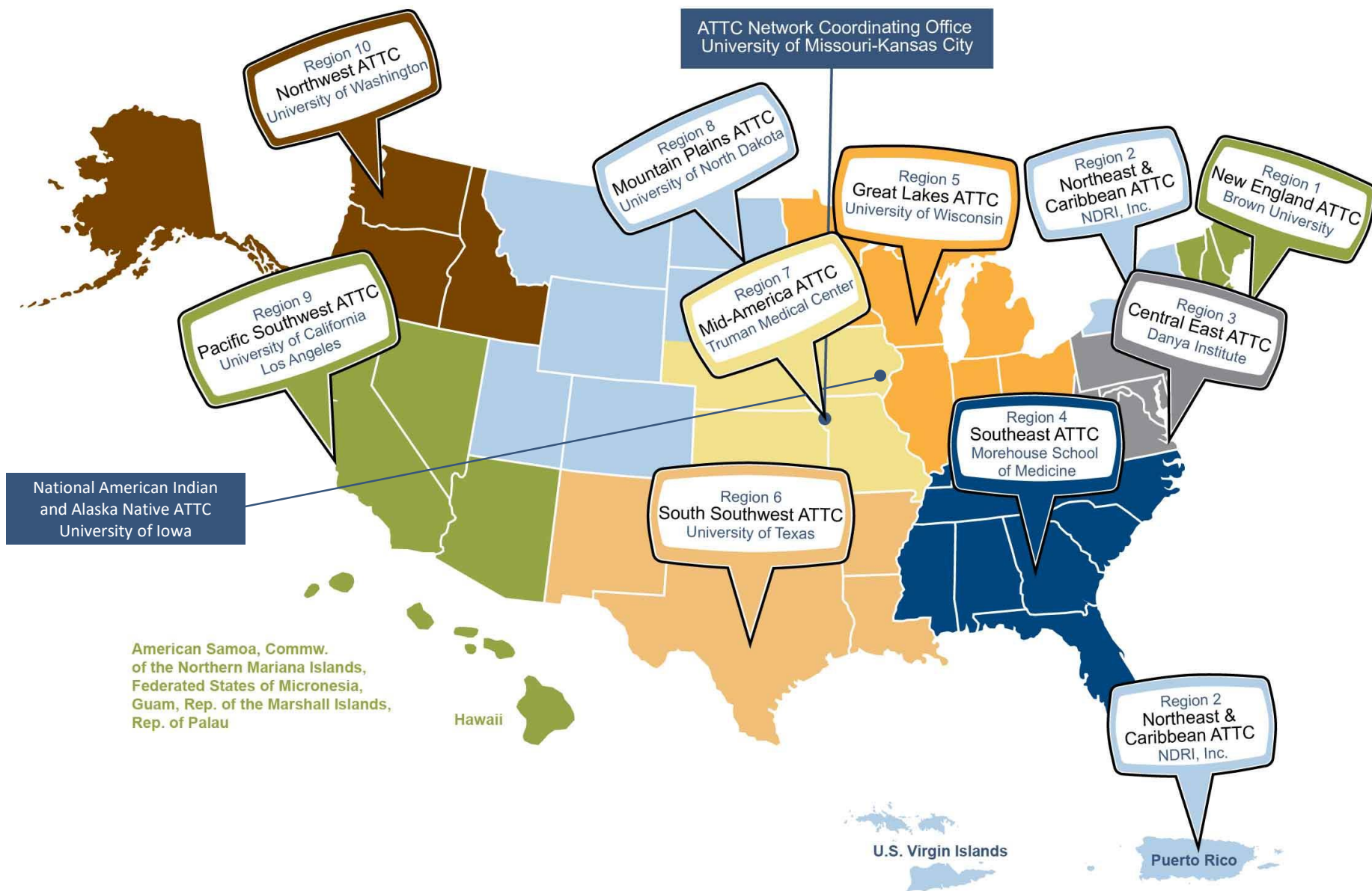
- Accelerate the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services;
- Heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use and/or other behavioral health disorders; and
- Foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community.



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Domestic ATTC Network





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10 Domestic ATTC Regional Centers

- Match the 10 HHS Regions
- Address multi-system issues
- Provide education, training and intensive technical assistance
- Develop region-specific products
- Utilize regional advisory boards
- Respond to needs of state/regional stakeholders, but may also develop specific areas of expertise
- Work to improve standards and policies in the field



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National Native Indian and Alaska Native ATTC

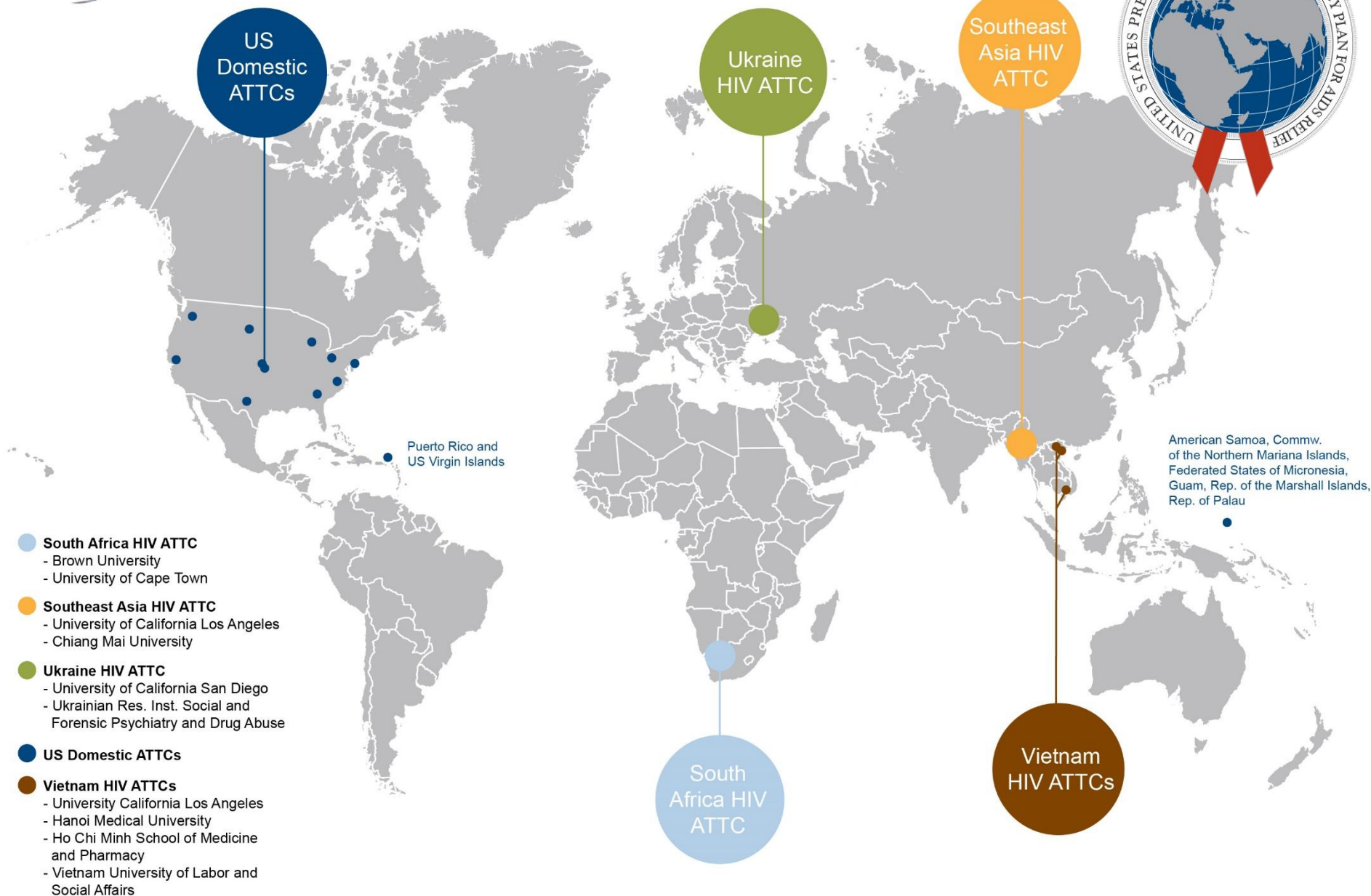
- Prepares tools and strategies needed to improve the quality of service delivery for tribal communities
- Provides intensive technical assistance to improve processes and practices in the delivery of SUD treatment and recovery services for tribal communities



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International ATTC Network





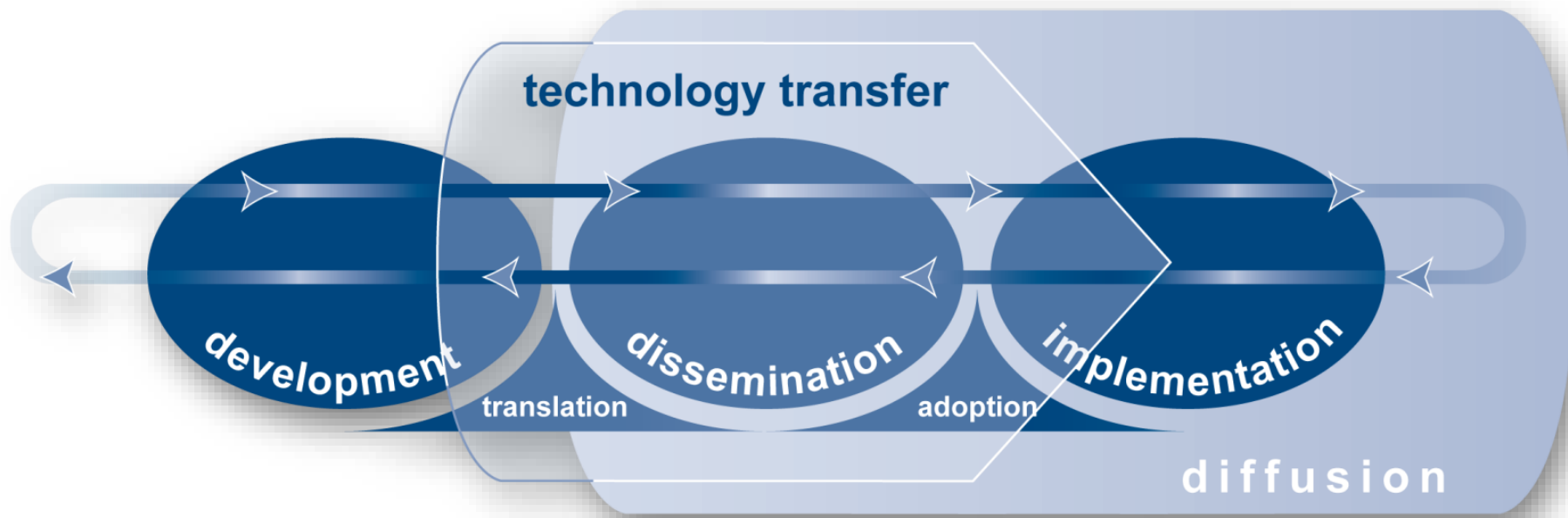
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Technology Transfer

How does the ATTC Network Accomplish the Mission?

The ATTC Network uses a comprehensive array of **technology transfer** strategies to accelerate the diffusion of innovations.

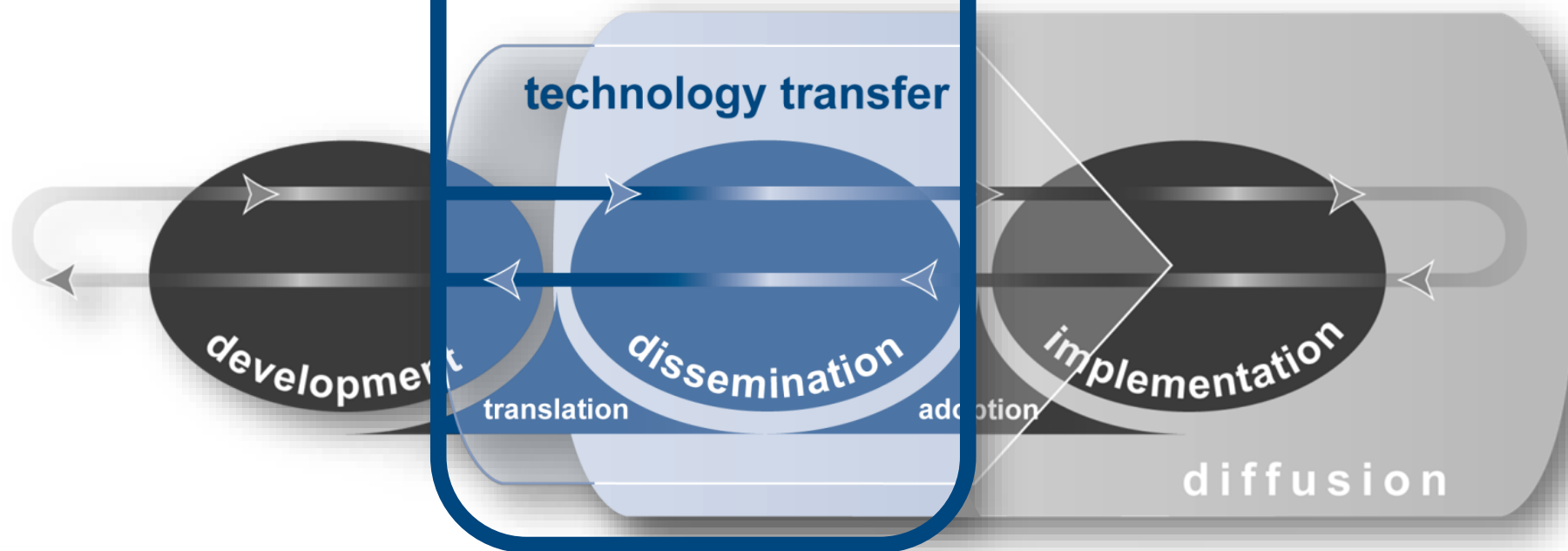




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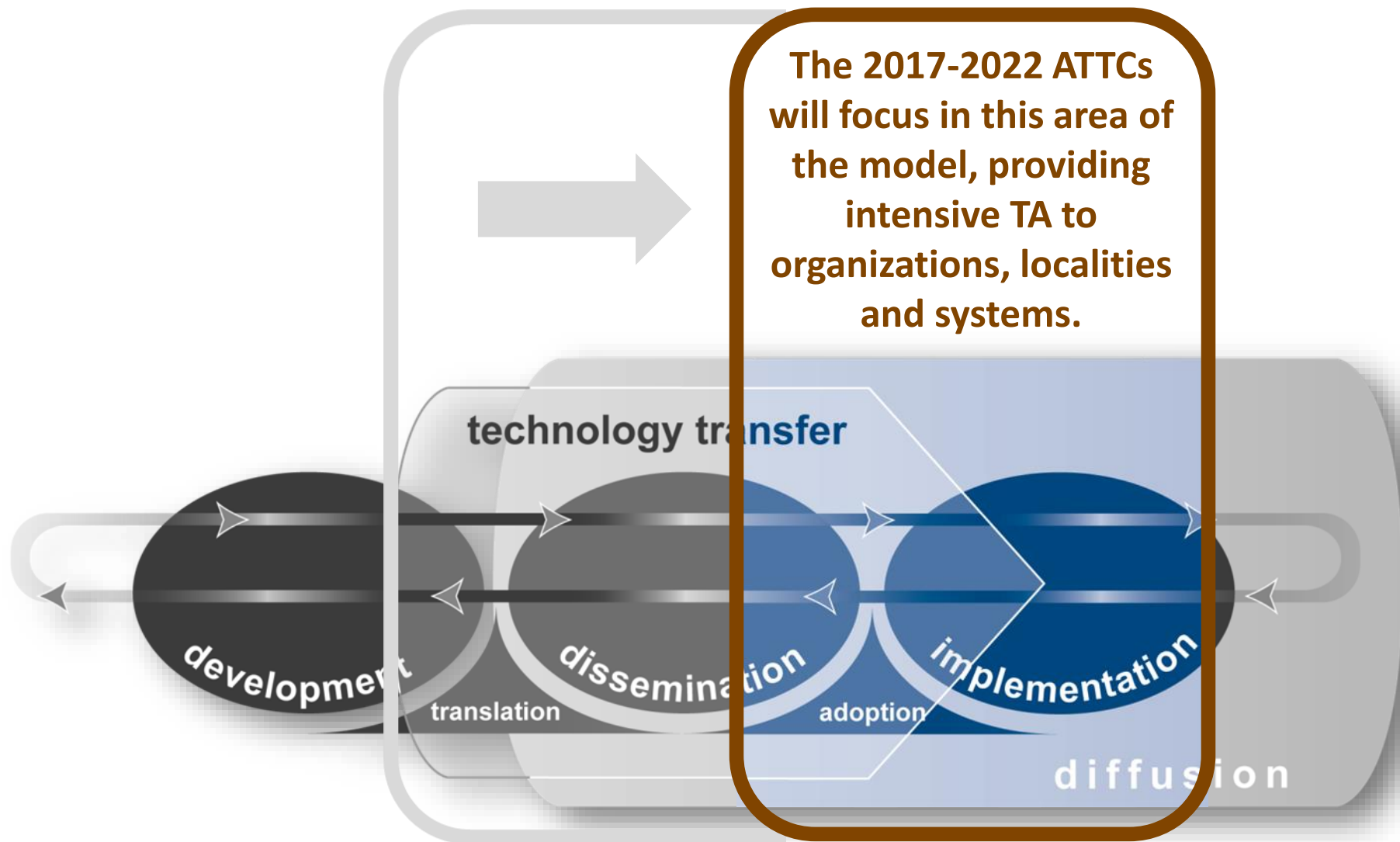
For 20+ years, the ATTCs have focused in this area of the model, providing numerous trainings to large numbers of participants.





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What does this shift in focus mean?

- ↓ Stand-alone, face-to-face training events
- ↓ Number of people served
- ↓ Educational events focused solely on developing the competencies of individuals
- ↑ Connected learning series and communities
- ↑ Organizational development and systems change projects
- ↑ Technical assistance to organizations, localities, and states





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Our Audience

- **Practitioners**
- **Students**
- **Systems**





What else is changing?

- Emphasis on self-paced and online courses
- Emphasis on distance learning paired with a hub and spoke technology framework (e.g., Project ECHO)
- Option of building mobile apps that support individuals in using newly learned skills
- Capacity building on the *National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare* (National CLAS Standards)
- Stronger role for ATTC Network Coordinating Office





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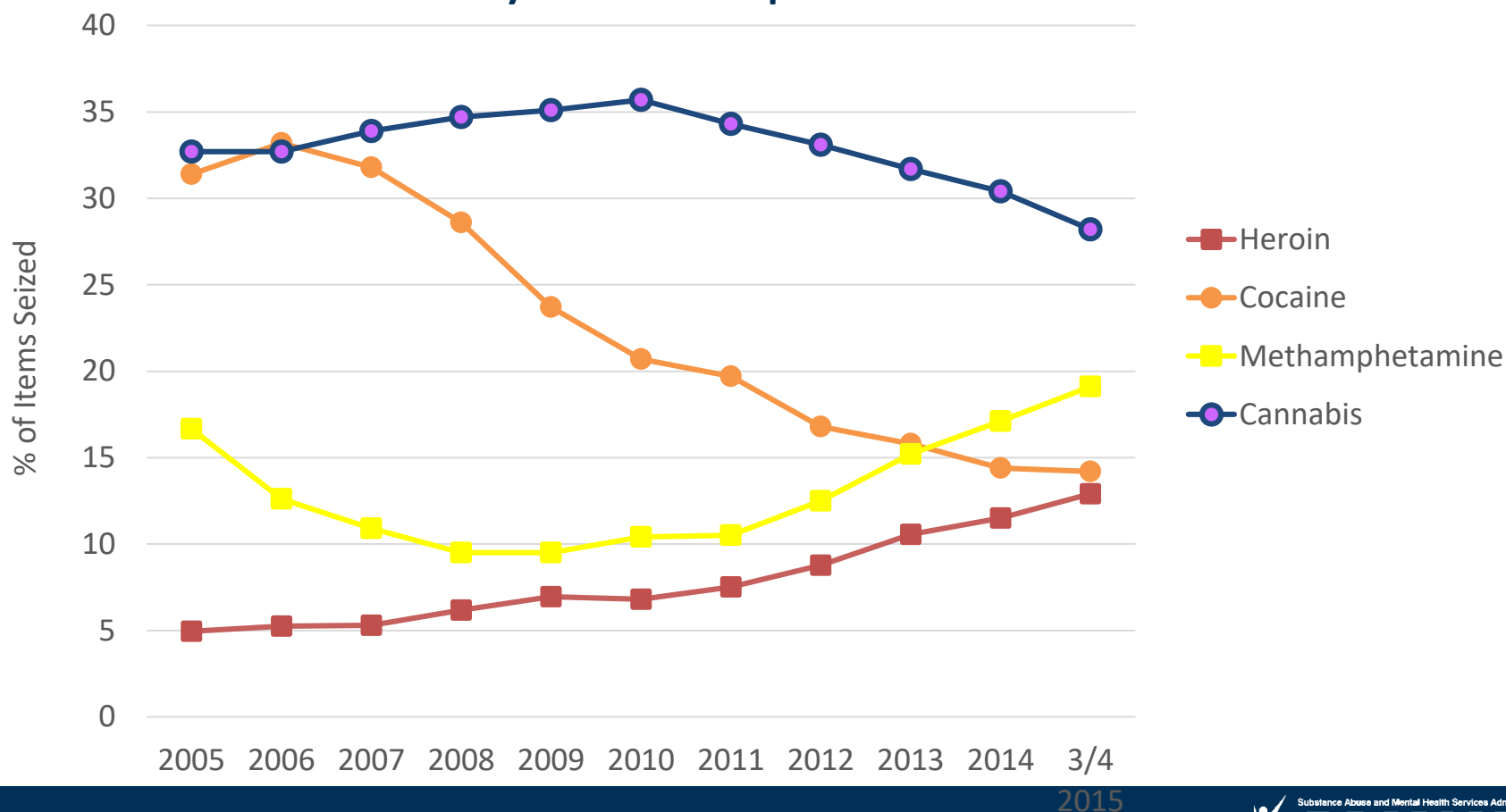
State of Substance Use Disorders (SUDs) Nationally and Regionally



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Percentage of Items Identified in DEA's National Forensic Laboratory Information System: January 2005-September 2015



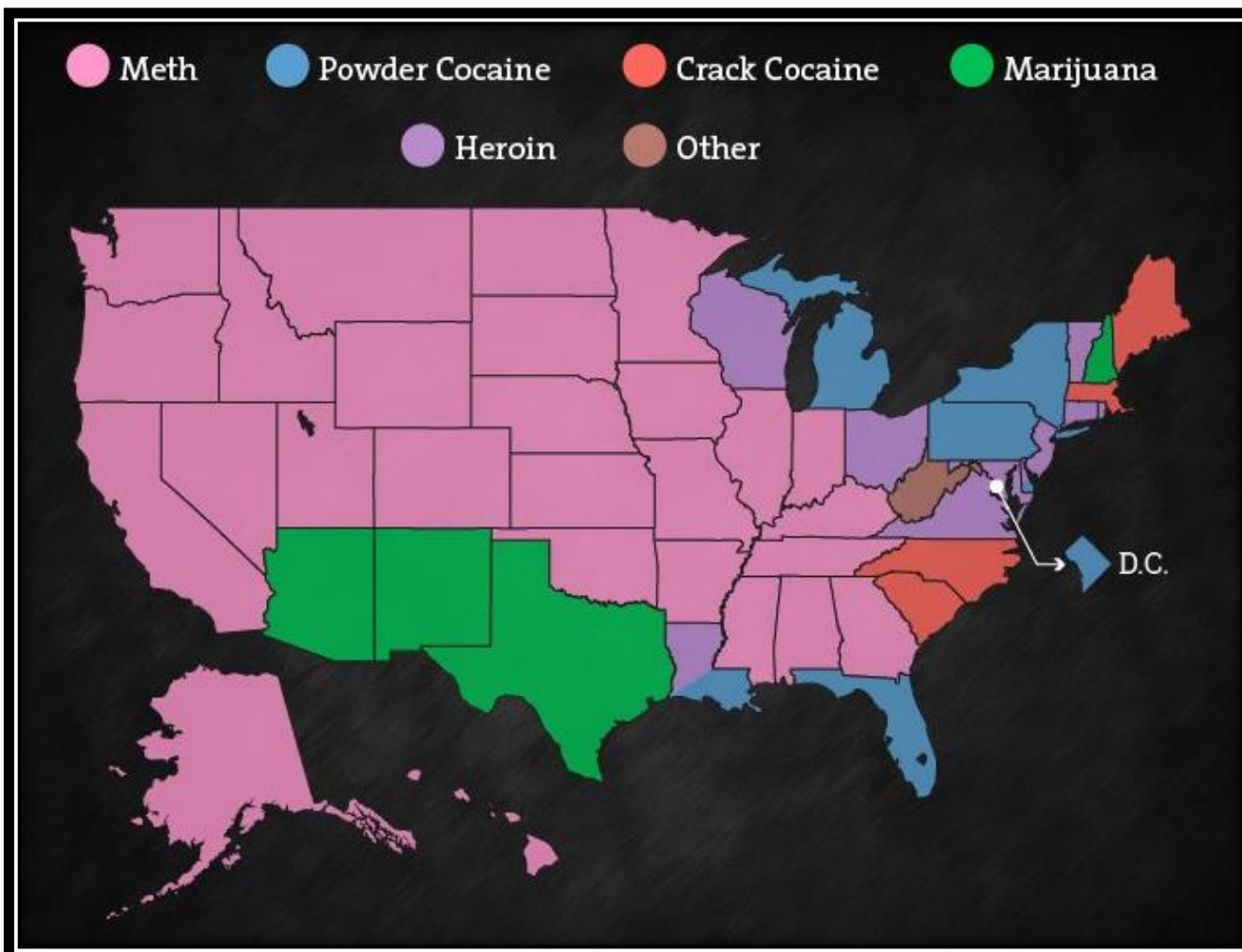
SOURCE: National Forensic Laboratory Information System, 2005-2015 (slide courtesy of Jane C. Maxwell, PhD).



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Top Drug Offenses, by State



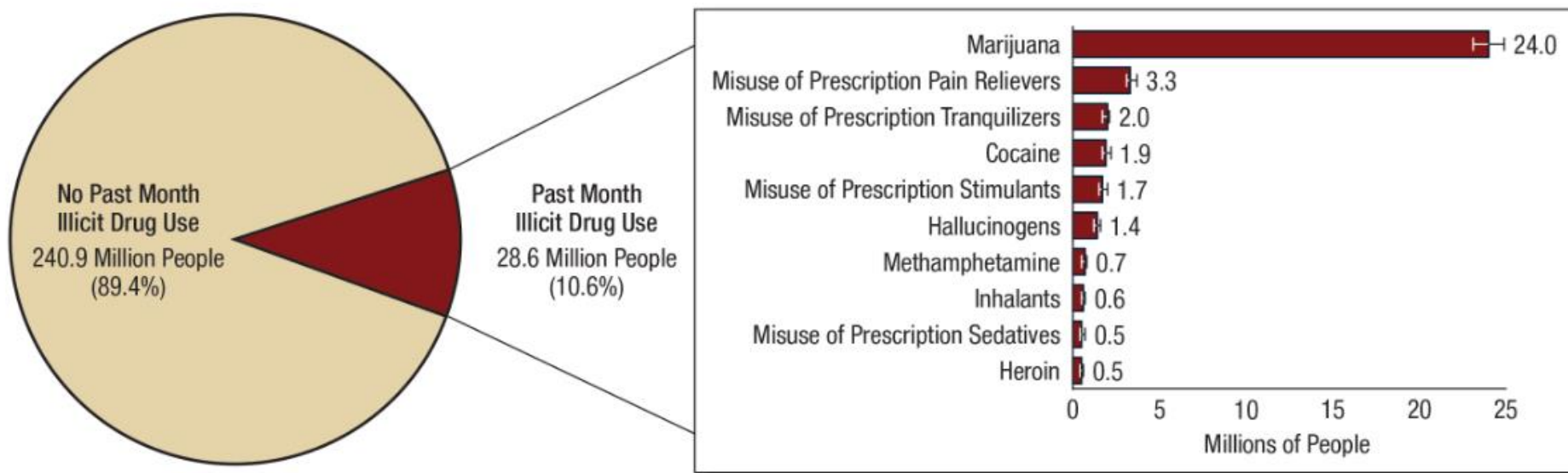
SOURCE: U.S. Sentencing Commission, 2016.



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Numbers of Past Month Illicit Drug Users among People Aged 12 or Older: 2016



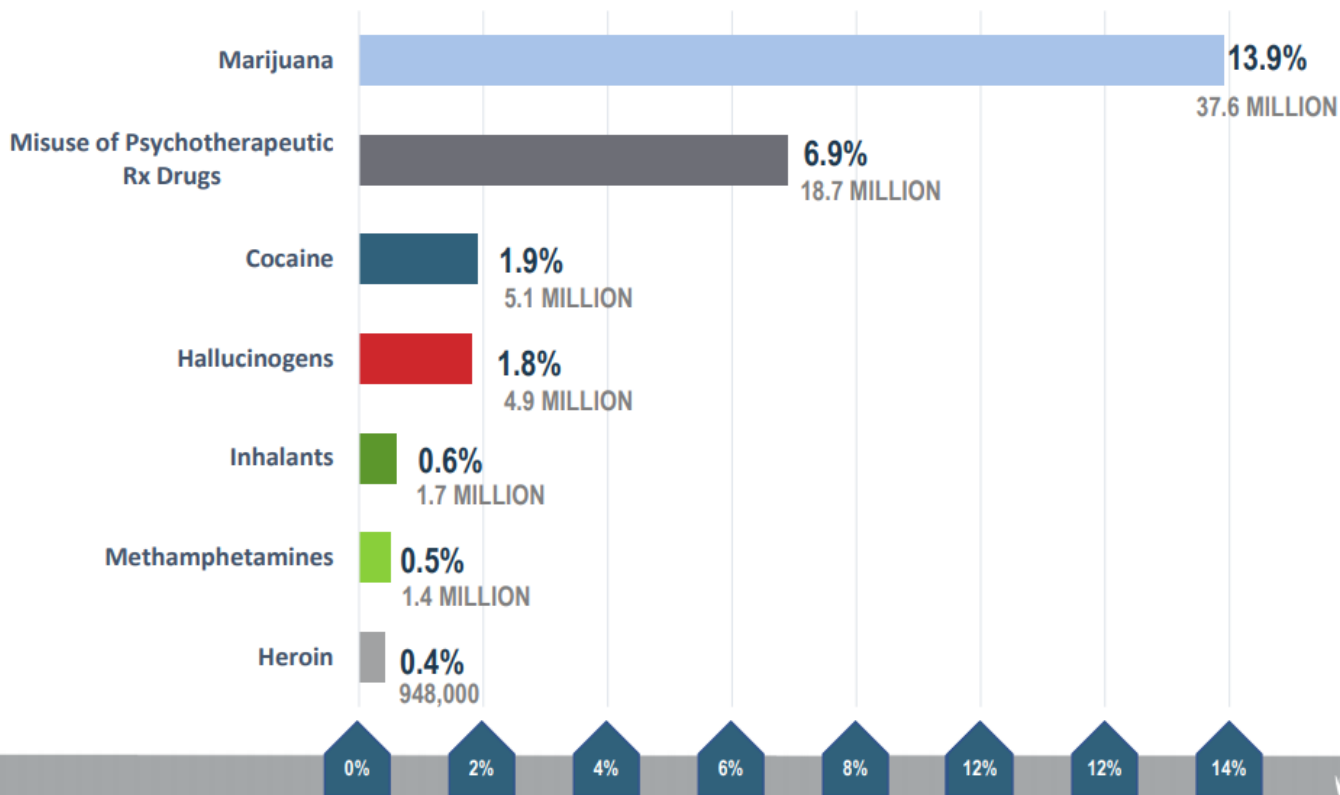


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ILLICIT DRUG USE IMPACTS MILLIONS: MARIJUANA MOST WIDELY USED DRUG

PAST YEAR, 2016, 12+



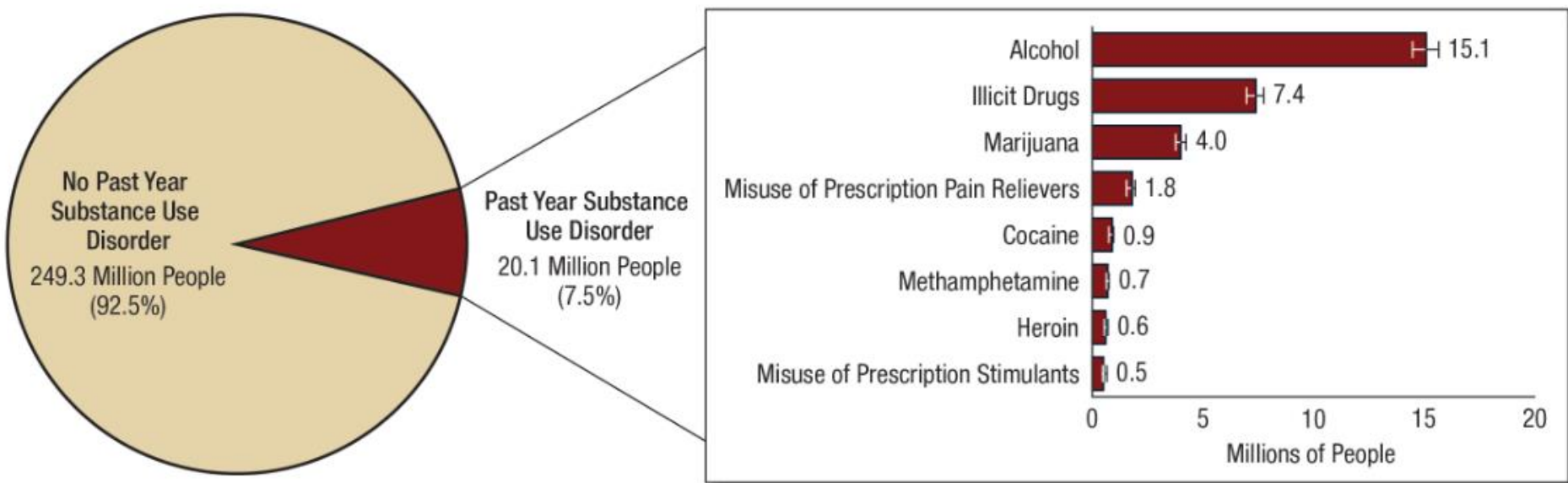
SAMHSA



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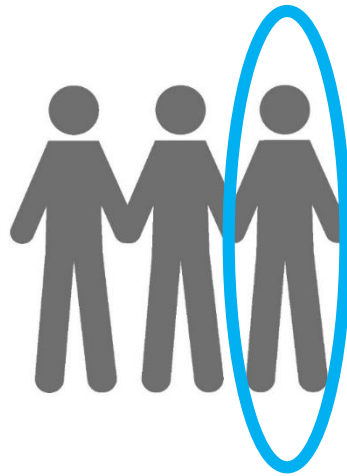
The Prevalence of Substance Use Disorders in the General US Population: 2016



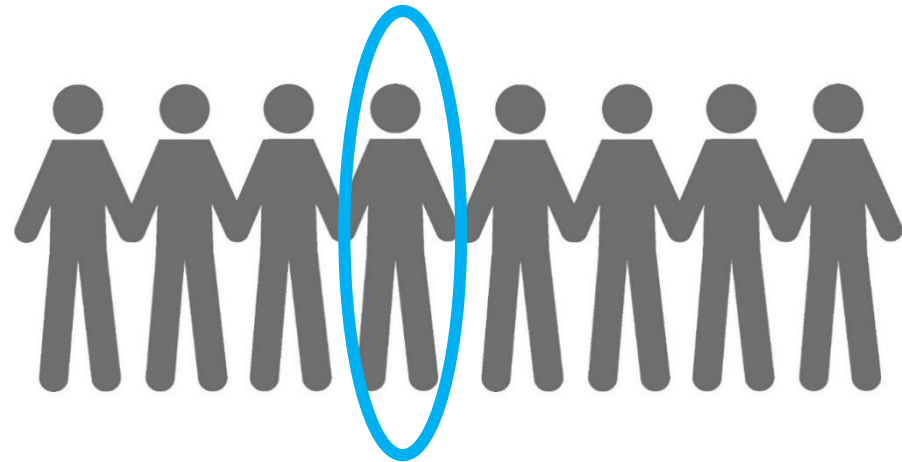
2016 National Drug Use and Health Survey



**3 out of 4 had an
alcohol use disorder**



**1 out of 3 had an
illicit drug use disorder**



**1 in 9 had both an
alcohol and illicit drug disorder**

Individuals with SUDs in the Past Year



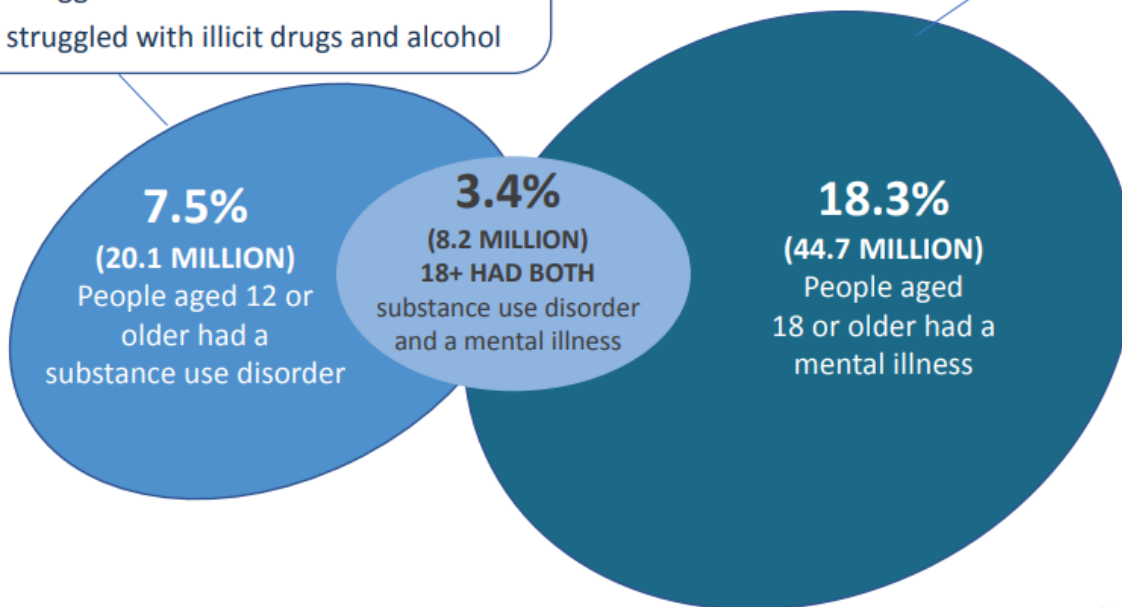
PAST YEAR, 2016, 12+

Among those with a substance use disorder about:

- **1 IN 3 (37%)** struggled with illicit drugs
- **3 IN 4 (75%)** struggled with alcohol use
- **1 IN 9 (12%)** struggled with illicit drugs and alcohol

Among those with a mental illness about:

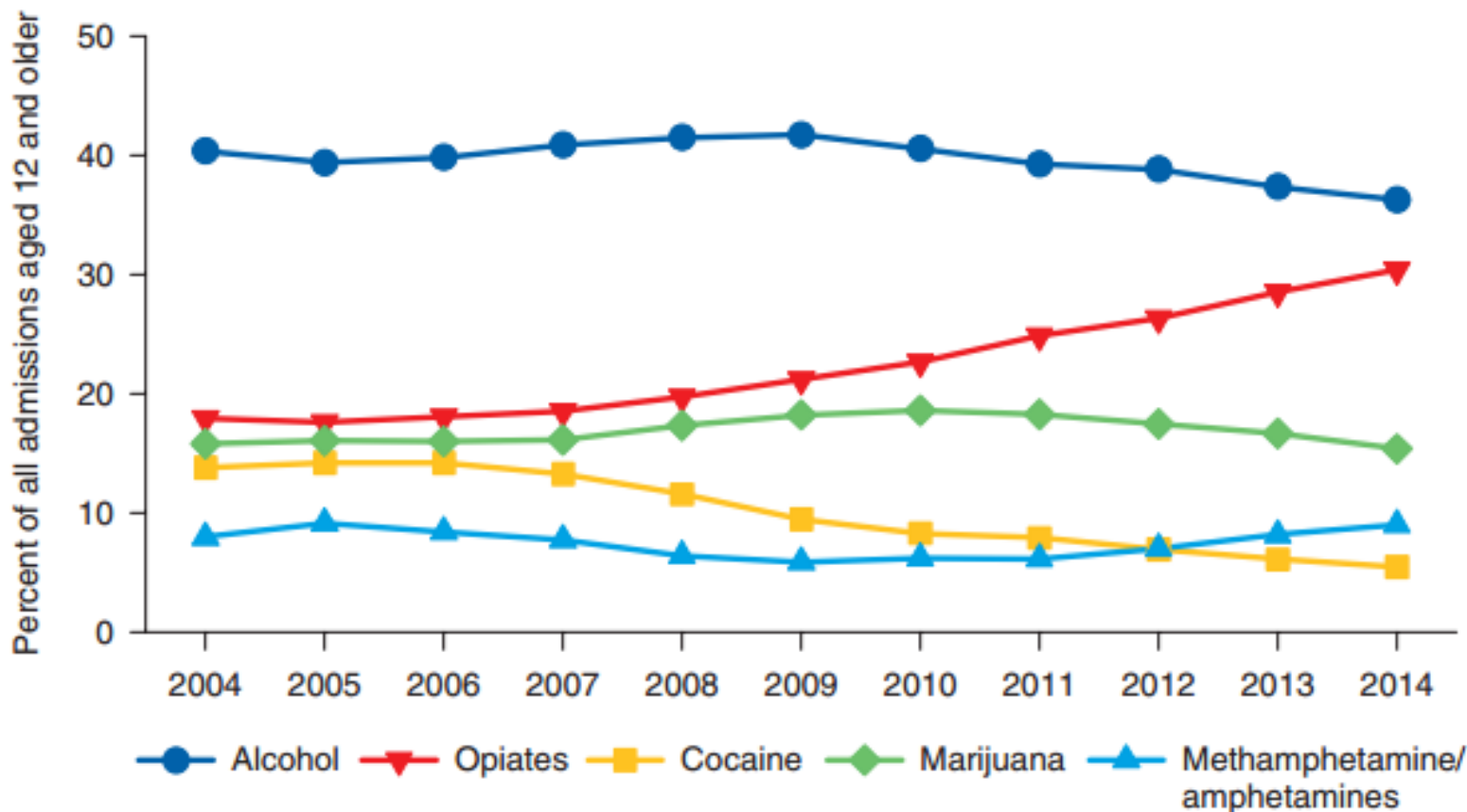
- **1 IN 4 (23%)** had a serious mental illness



No statistically different changes from 2015



Primary Substance of Abuse at Admission: 2004-2014

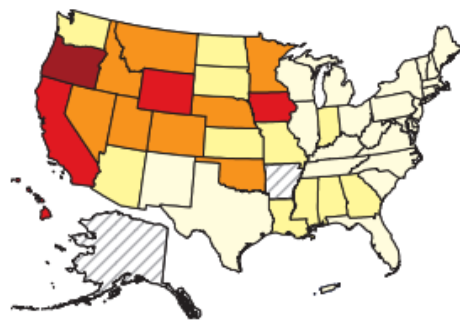




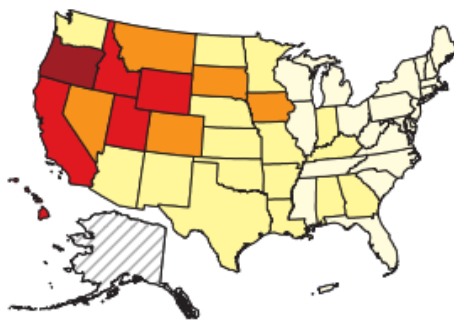
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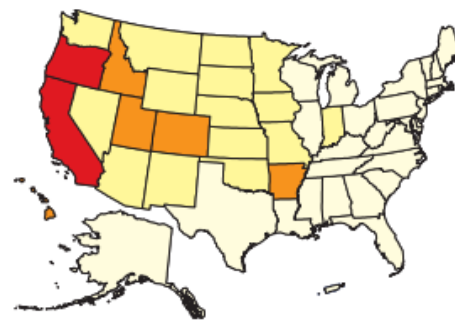
Primary Stimulant Rates, by State/Jurisdiction: 2004-2014



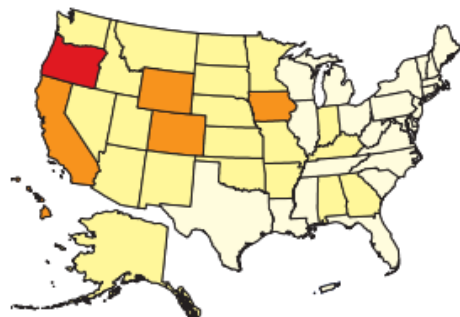
2004
(range 1 – 283)



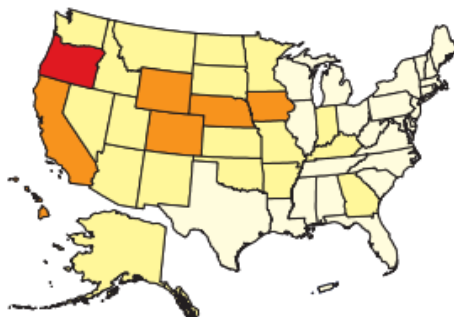
2006
(range 3 – 297)



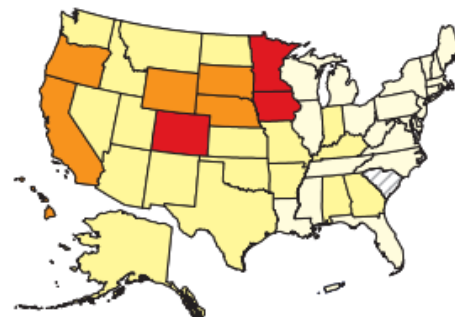
2008
(range <1 – 234)



2010
(range 1 – 219)

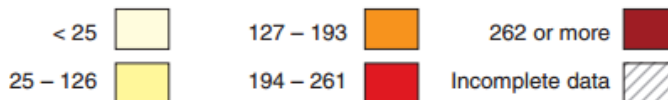


2012
(range <1 – 217)



2014
(range <1 – 213)

KEY YEAR: 2004



NOTES: See Chapter 1.

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 2.01.16.



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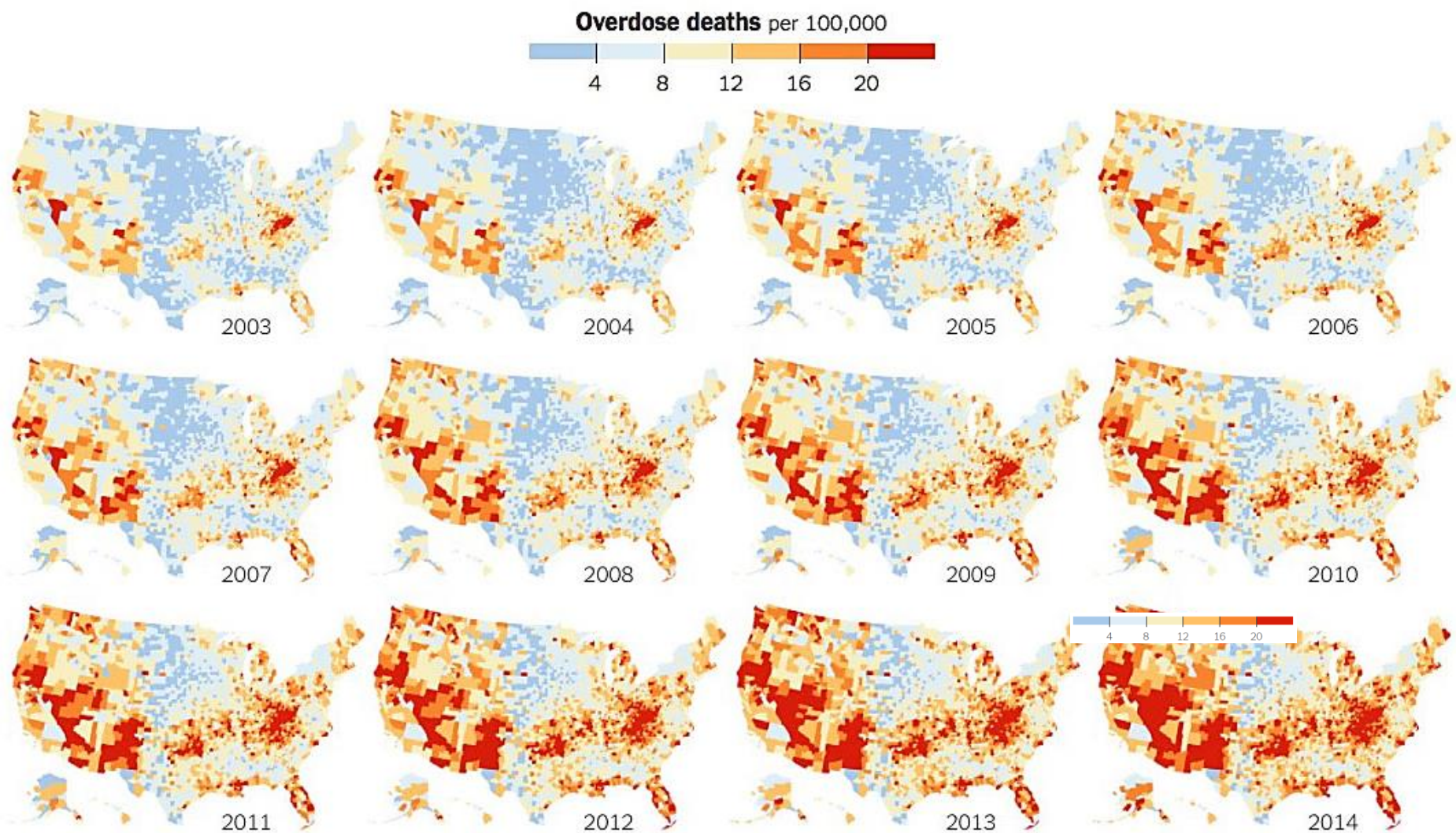
Opioid Use



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Overdose Deaths per 100,000



New York Times: <https://nyti.ms/2jVUIKb>

Opioid Overdose Deaths (63,600) in 2016 were **HIGHER** than the number of people:

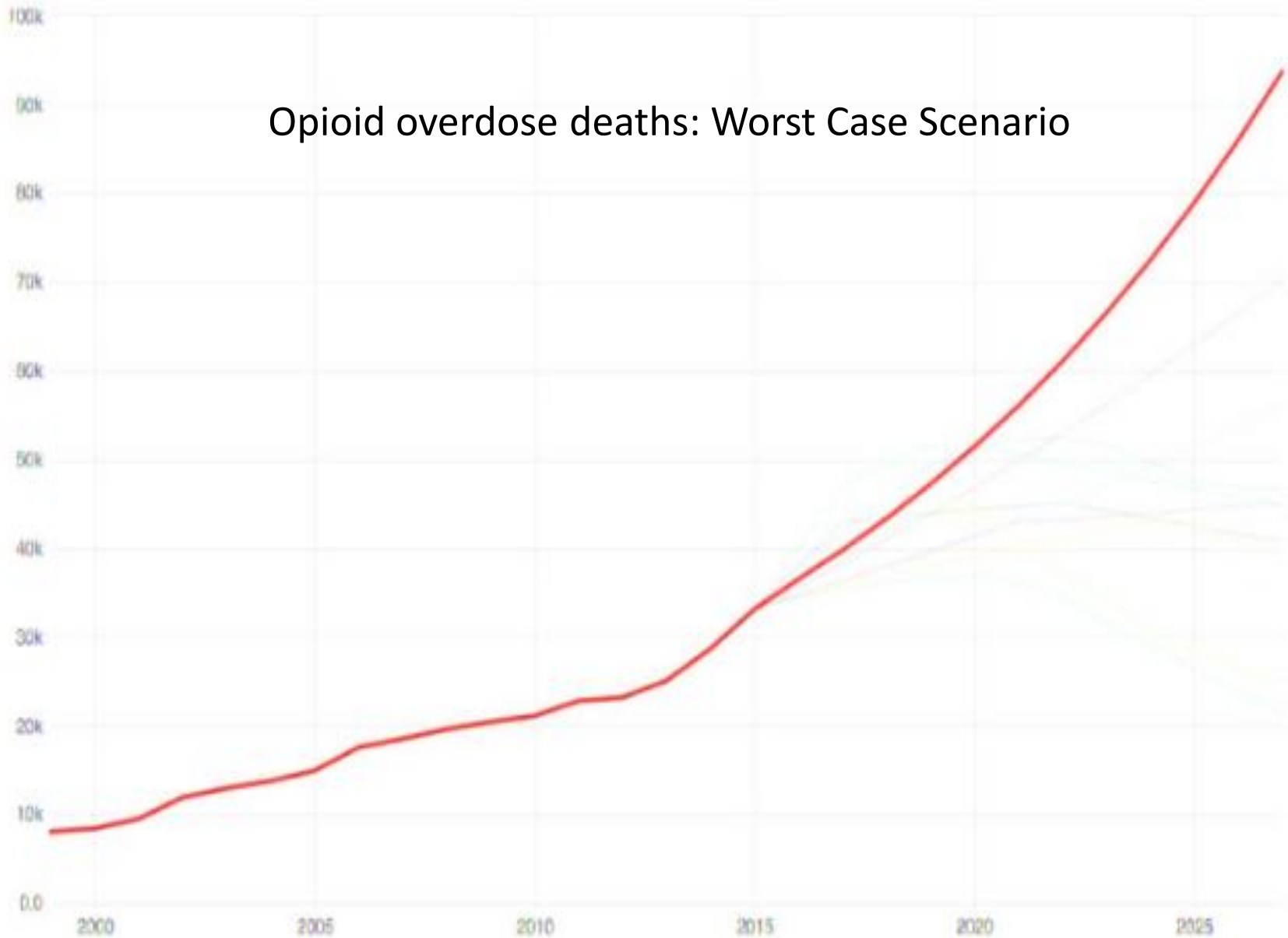
- killed in Vietnam (US Military) 58,220¹
- that died from HIV/AIDS at the height of the epidemic (1995) 48,371²
- killed in motor vehicle accidents 37,574³
- with alcohol-induced deaths 33,171³
- murdered 17,793³

¹ <https://www.archives.gov/research/military/vietnam-war/casualty-statistics.html>

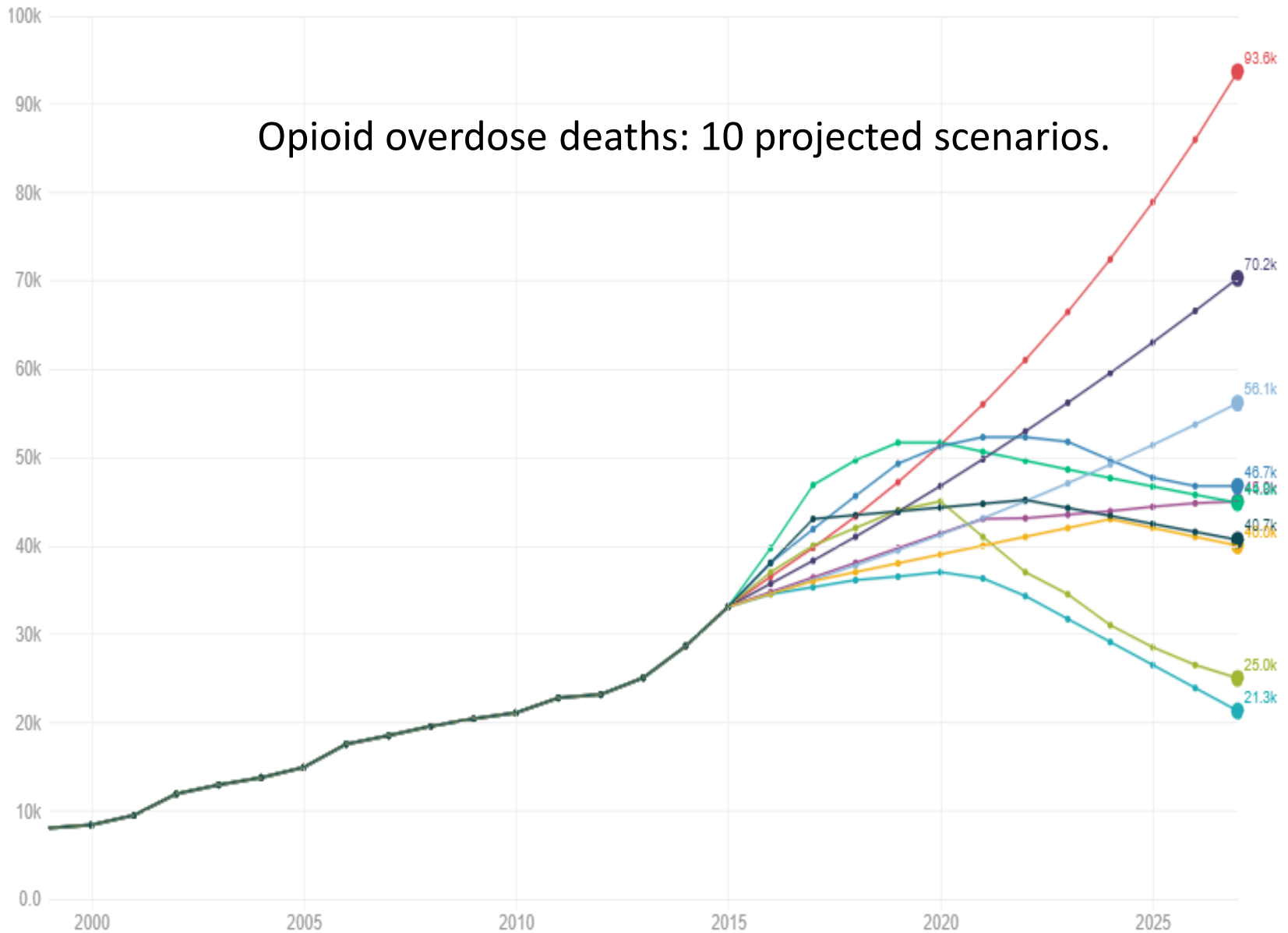
² <http://www.factlv.org/timeline.htm>

³ http://www.drugwarfacts.org/chapter/causes_of_death

Opioid overdose deaths: Worst Case Scenario

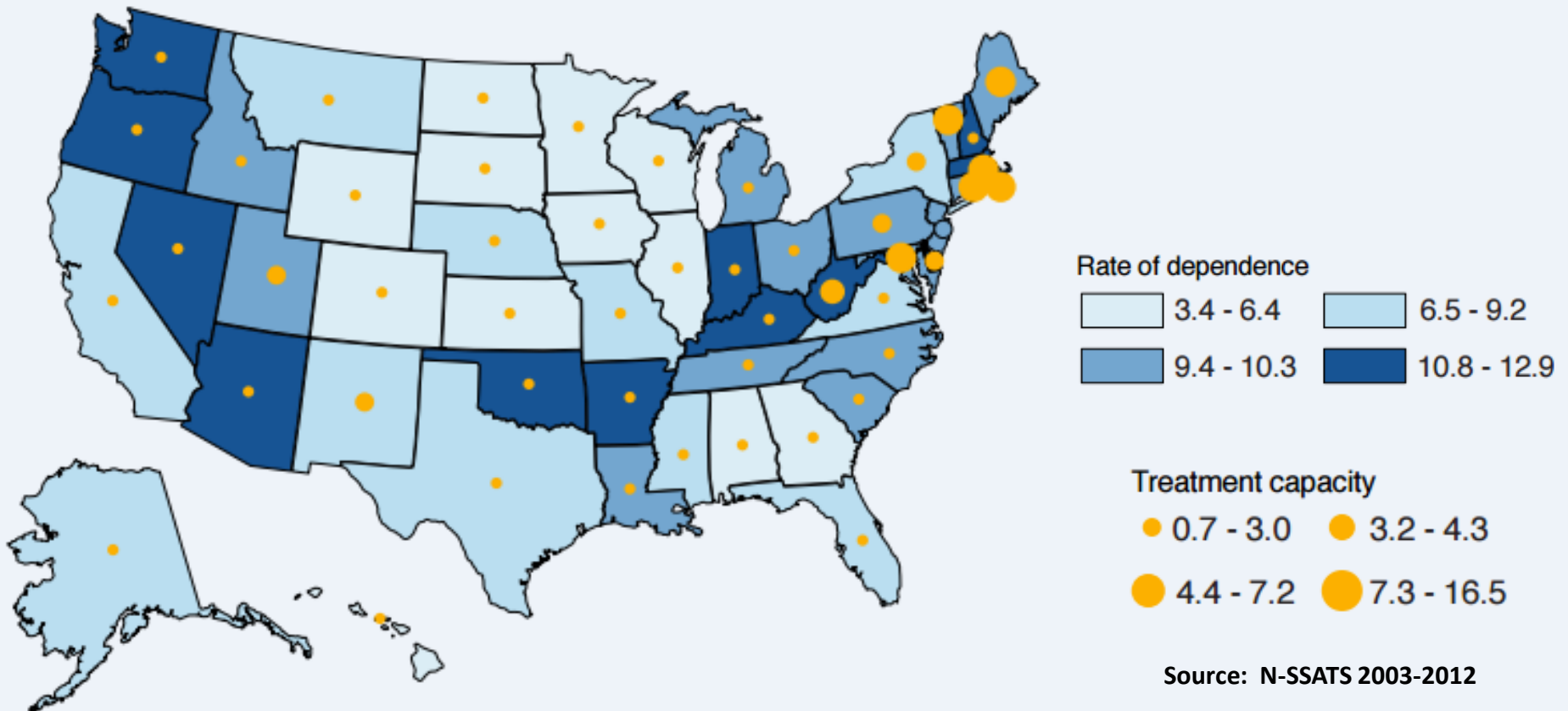


Opioid overdose deaths: 10 projected scenarios.



Rate of Past Year Opioid Abuse or Dependence* and Rate of Medication Assisted Treatment Capacity with Methadone or Buprenorphine

Rate per 1,000 persons aged 12 years and older

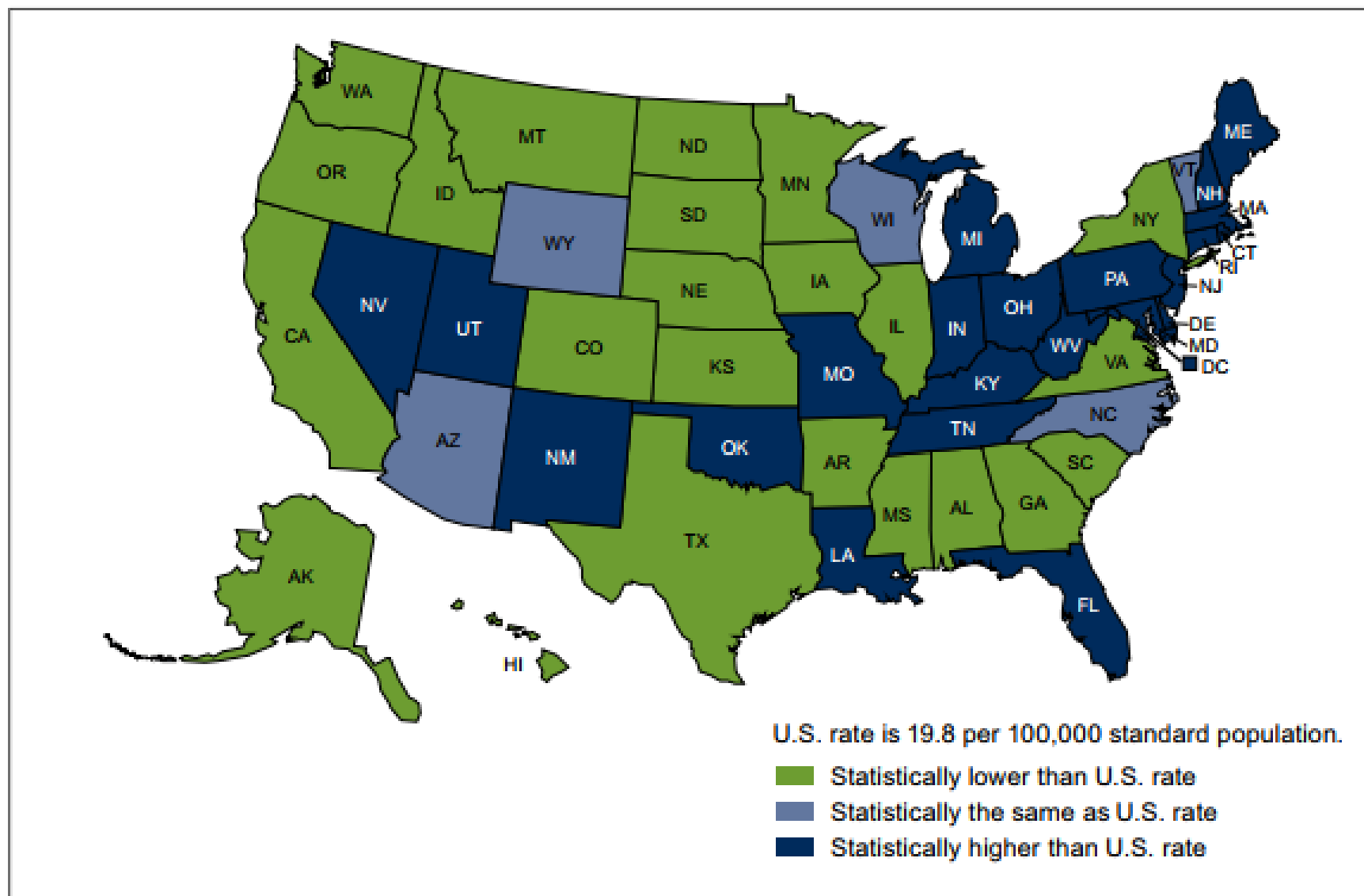


Source: N-SSATS 2003-2012

*Opioid abuse or dependence includes prescription opioids and/or heroin

Source: AJPH 2015; 105(8):e55-63

Age-adjusted drug overdose death rates, by state: United States, 2016



Age-Adjusted Overdose Rates by State in 2016

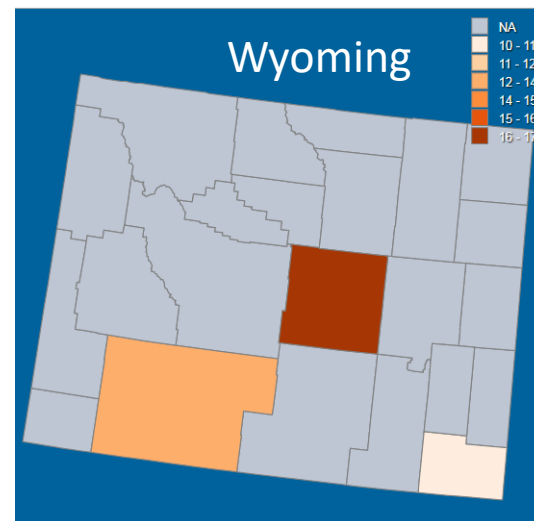
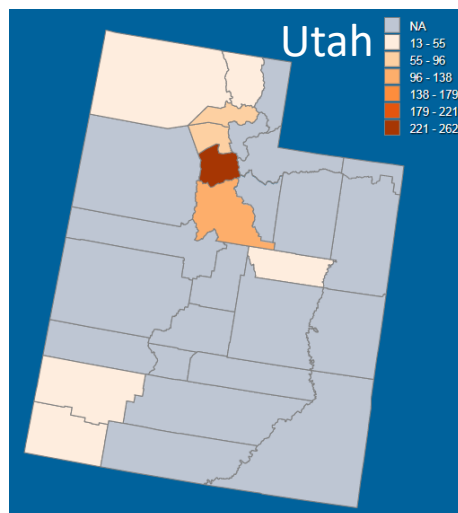
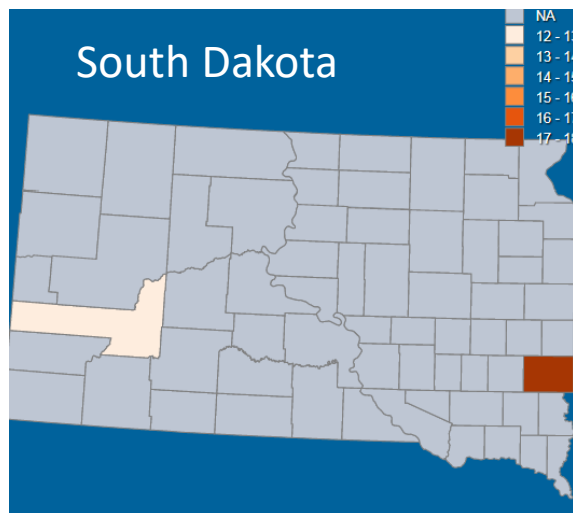
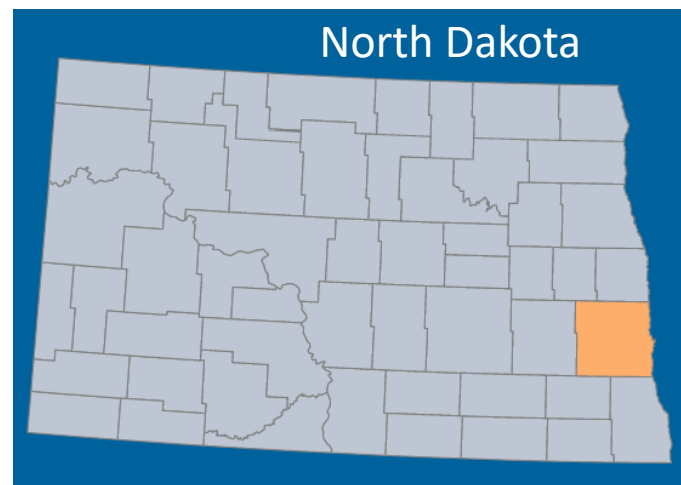
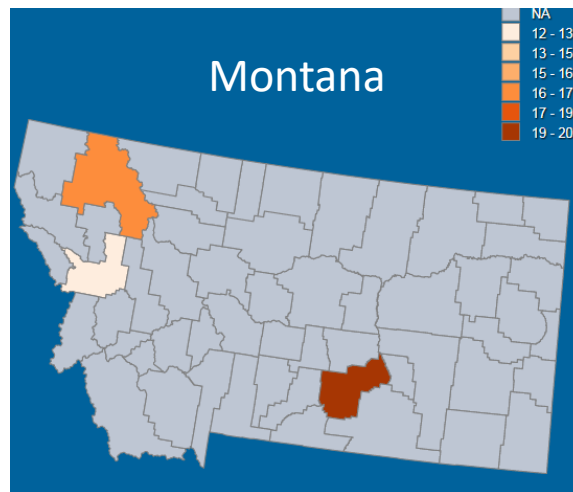
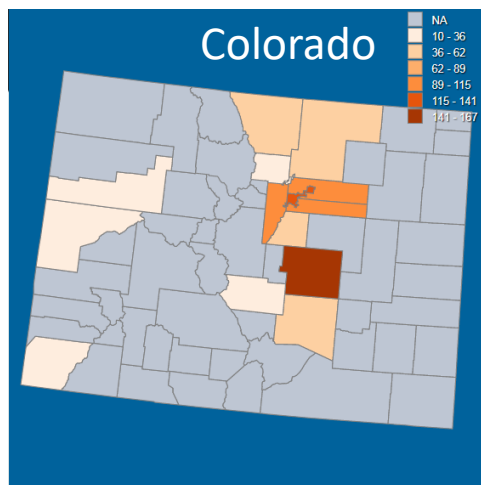
- **5** states had the highest observed age-adjusted drug overdose death rates
 - West Virginia - 52.0; Ohio - 39.1; New Hampshire - 39.0; Pennsylvania - 37.9; and the District of Columbia - 38.8
- **17** states had drug overdose death rates that were higher than the national rate of 19.8 per 100,000:
 - UT - 22.3; LA - 21.8; NM - 25.2; OK - 21.5
- **5** states had rates comparable to the national rate:
 - WY - 17.6
- **23** states had lower rates:
 - CO - 16.6; MT - 11.7; ND - 10.6; SD - 8.4; KS - 11.1
- **5** had the lowest observed age-adjusted drug overdose death rates
 - ND - 10.6; SD - 8.4; IA - 10.6; NE - 6.4; TX - 10.1



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Region 8 Drug-Related Deaths



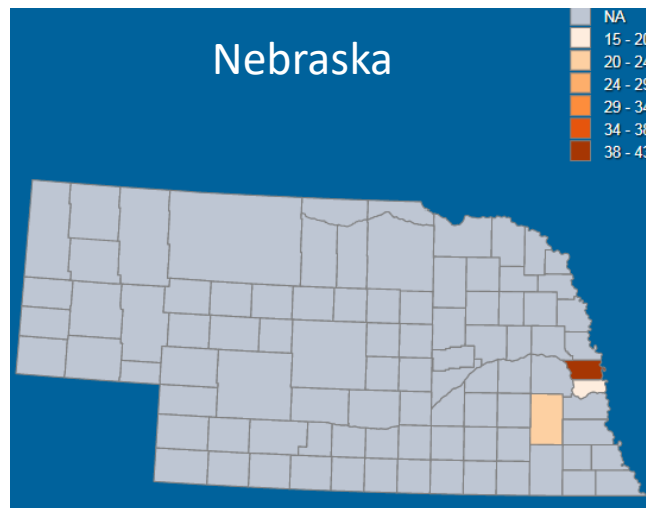
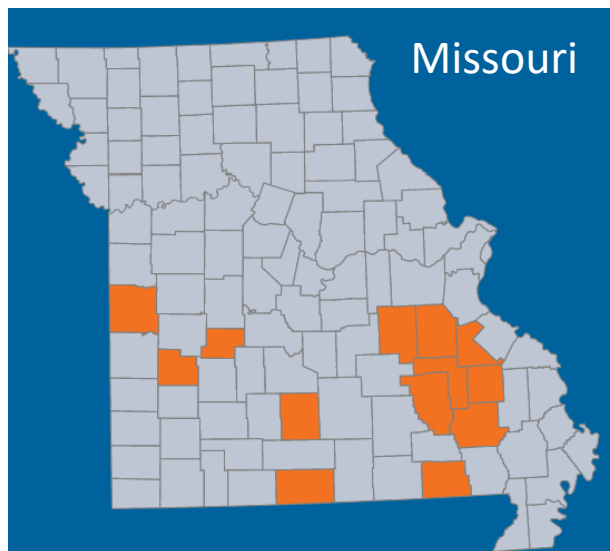
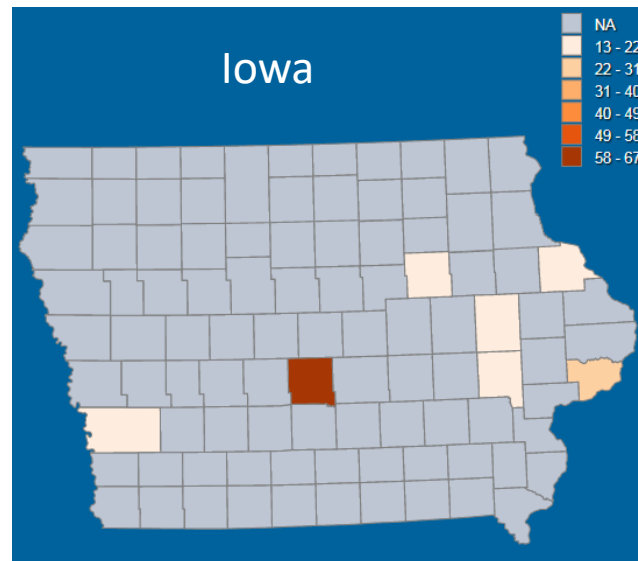
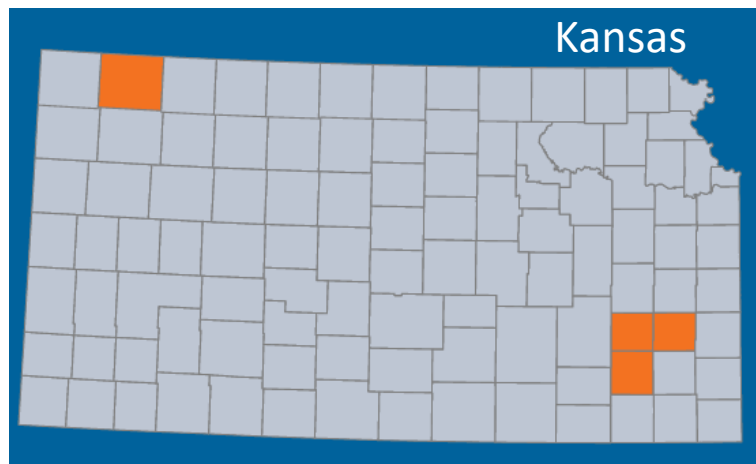
<http://opioid.amfar.org/indicator/drugdeaths>



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Region 7 Drug-Related Deaths



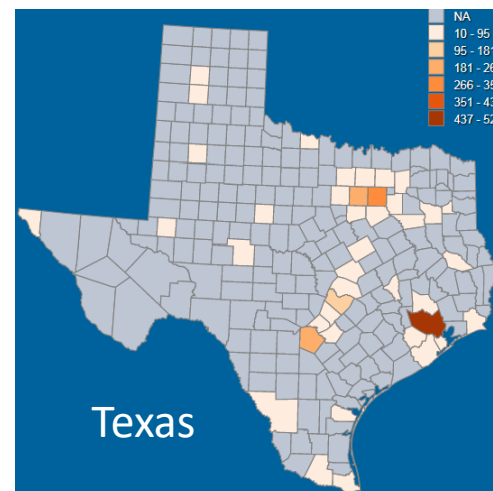
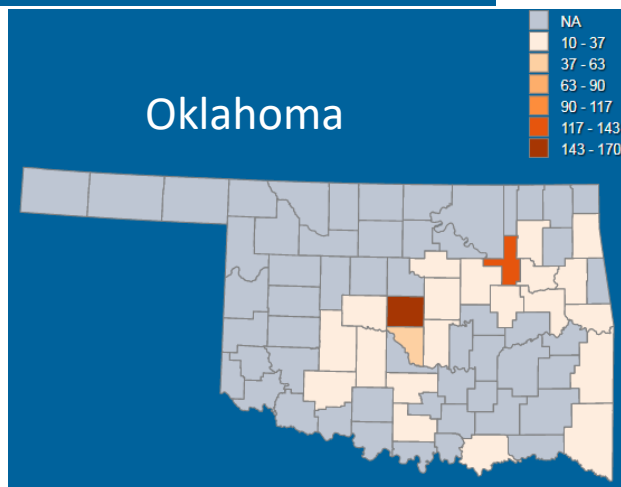
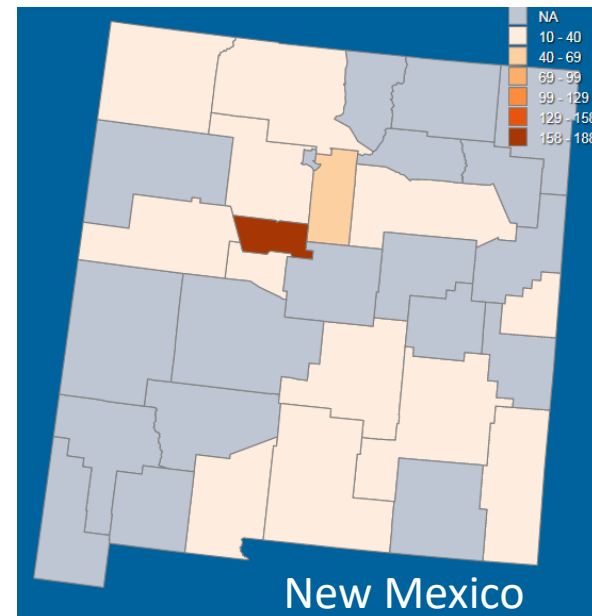
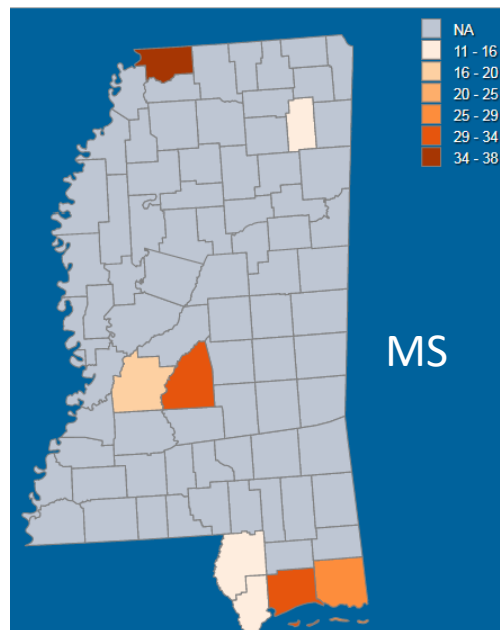
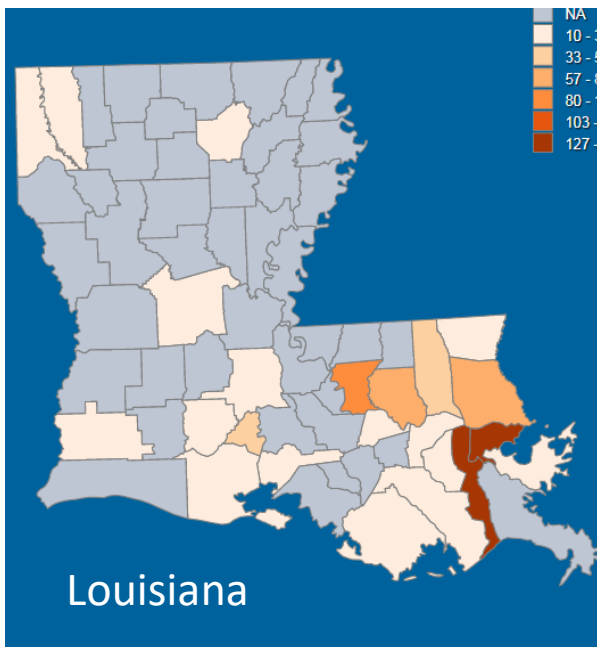
<http://opioid.amfar.org/indicator/drugdeaths>



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Region 6 Drug-Related Deaths



<http://opioid.amfar.org/indicator/drugdeaths>



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Good Samaritan Laws


As of July 15, 2017:

- All 50 states and DC passed legislation to improve layperson's access to naloxone
- 40 states and DC have passed legislation that provides some protection from arrest or prosecution for individuals who report an overdose
- Six of these ten states include: IA; KS; MO; OK; TX; WY

(The Network for Public Health Law Robert Wood Johnson Foundation; Davis & Chang, 2017)
https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf

Addressing Prescription Opioid Misuse/Overdose Issues in Rural Areas





**In rural areas, deaths
from unintentional
overdose have increased
by **>250%** since 1999,
while urban deaths have
increased at a fraction of
this rate.**

Four Factors that Explain Rural Opioid Overdose/Use Rates



- 1. Increased sales of opioid analgesics (high prescription rates) in rural areas lead to greater availability for non-medical use through diversion.**

2. Out-migration of upwardly mobile young adults from rural areas increases economic deprivation and creates an aggregation of young adults at high risk for drug use.



3. Tight kinship and social networks allow faster diffusion of non-medical prescription opioids among those at risk.





**Most common offer-ers
included cousins or
relatives of the same age
or slightly older**

4. Increasing economic deprivation and unemployment create a stressful environment that places individuals at risk.



summary

‘The crisis of nonmedical use of prescription opioids is an important public health priority and the greatest threat remains concentrated in rural, low-income areas of the United States.’

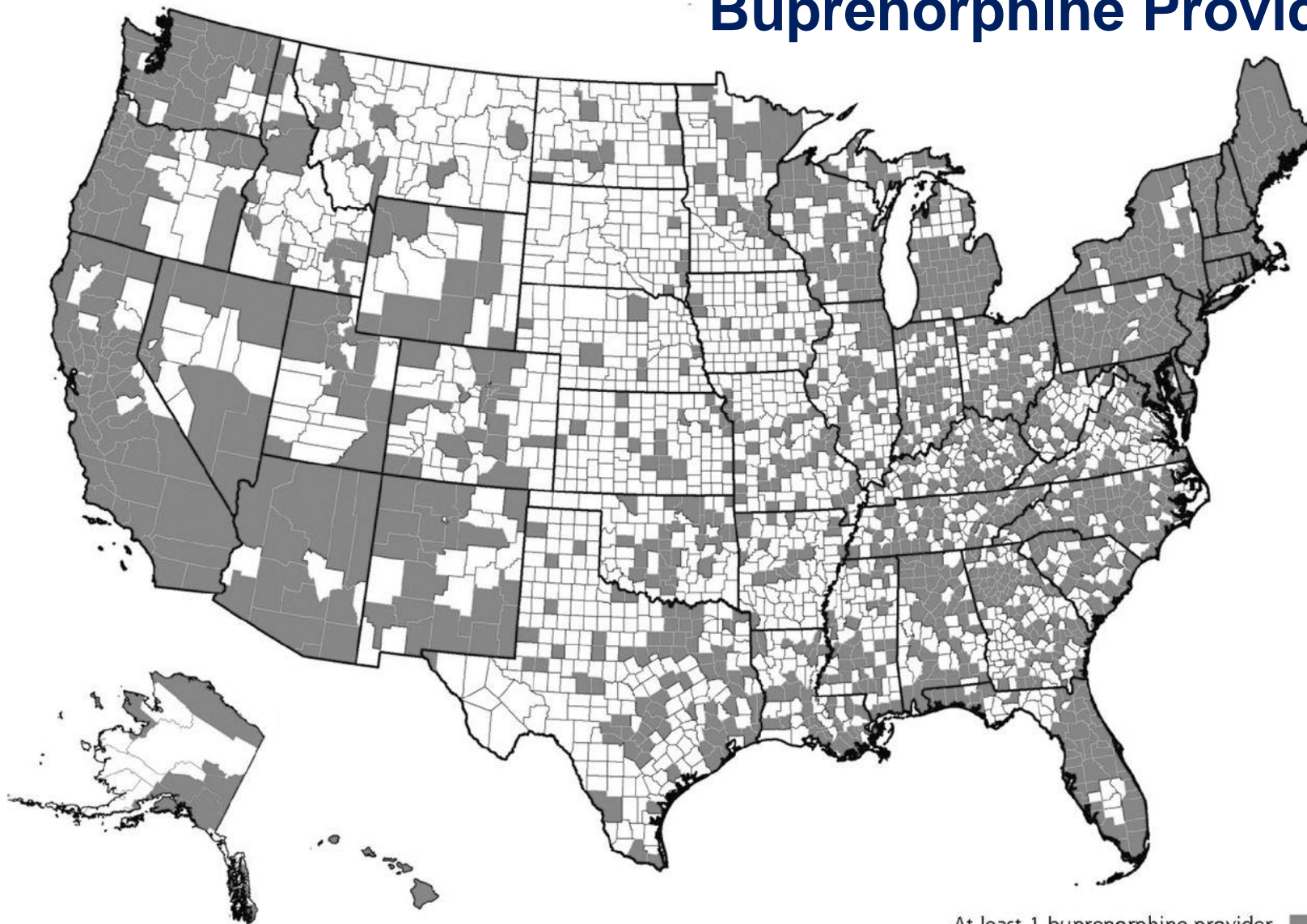
Social norms, cultural traditions, attitudes, availability, and policies are all critical to understanding broad differences in prevalence of substance use...’



Access to healthcare is the number one issue that has the most negative impact or effect ...



(Bolin, 2015; Rural Healthy People, 2020)

Counties With and Without a Buprenorphine Provider



At least 1 buprenorphine provider 
No buprenorphine providers 

Data Supporting Increases in Rural Overdoses

- In 2015 **82.5%** of rural counties in the United States lacked a physician with a Drug Enforcement Agency waiver to prescribe buprenorphine, which severely limited access to medication assisted treatment (MAT).
- Access to naloxone and bystander training was limited or non-existent and many communities did not have timely access to first responders.

Training the Workforce in Rurality

Approximately 55 % of United States (U.S.) counties, all of which are rural, have no specialty mental health professionals (Hoge et al., 2007)

These workforce challenges are likely to be exacerbated by the growing demand for substance use treatment including treatment for opioid use disorders (OUDs) (Gale et al., 2017)



Perhaps the two most significant obstacles to providing high-quality mental and behavioral health care in rural America are workforce issues and include the persistent shortage of trained specialists and professional/personal isolation.

(Deleon, Kenkel, & Shaw, 2012)



Equipping clinicians and prevention specialists-in-training with an understanding of rural culture can help them ensure that they deliver the best possible care/services



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Providing integrated services
including SUD, MH, and
Physical Health is critical!!





Why Is Integration Important?

- Adults with **SUD die 26 years earlier**, again due to physical health problems related to their long-term substance use (LA County, 2015)
- Adults with **serious mental illness die 25 years earlier**, largely as a result of treatable medical conditions (NAMI, 2013)
- **Serious mental illness costs America \$192.2 Billion** per year in lost earnings. (NAMI, 2013)
- **27 physical illnesses occur more often in consumers with alcohol addiction** including the liver, pancreas, airways, gastrointestinal tract, and nervous system. (Medical News Today, 2015)



Medical Conditions that commonly co-occur with mental health and substance use

- Pain
- Diabetes
- Hypertension
- Obesity

By treating physical, mental and substance-related health issues together we ensure that the **the right care to the right patient at the right time – every time.**



Community Partnerships

By providing integrated care with active community partners, we actualize the continuum of services

- **Prevention** to help avoid these disorders.
- **Intervention and treatment** to address symptoms as they arise and treat disorders as early as possible.
- **Medical services** to provide necessary medicines and treat underlying medical issues and complications.
- **Recovery support services** peer support and additional service to aid with reintegration, continue positive change, and identify symptom exacerbation



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Newly Released



<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorders-Executive-Summary/SMA18-5063EXSUMM>

Federal Opioid Resources

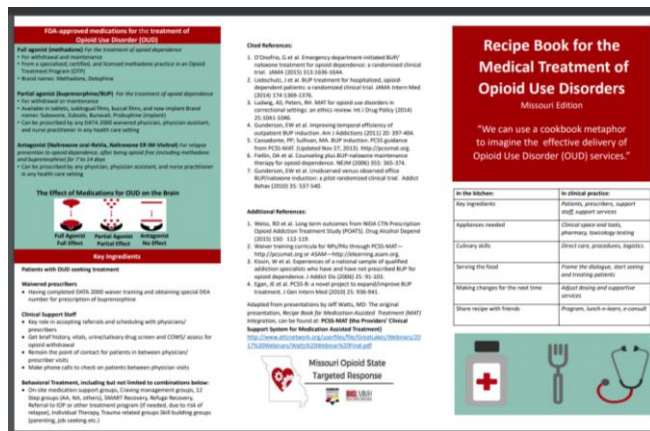
- Federal Grant Response: State Abstracts
<https://www.samhsa.gov/sites/default/files/grants/pdf/other/ti-17-014-opioid-str-abstracts.pdf>
- NIDA Opioid Overdose Crisis brief
<https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>
- HHS: About the US Opioid Crisis
<https://www.hhs.gov/opioids/about-the-epidemic/index.html>
- [NIDA's Naloxone Resources webpage](#)
- [NIDA's Treatment Approaches for Drug Addiction DrugFacts](#)
- Substance Abuse and Mental Health Services Administration's [Opioid Treatment Program Directory](#)

State Resources - Examples from 3 Regions



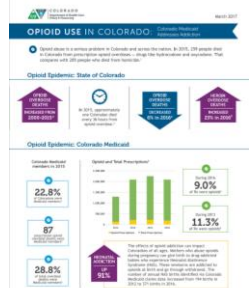
MO Recipe Book for MAT

https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/5a3d104b53450a0cd1f83597/1513951308796/Recipe+Book+for+OUD+Treatment_11x17.pdf



CO Infographic

<https://www.colorado.gov/pacific/sites/default/files/Opioid%20Use%20in%20Colorado%20-%20March%202017.pdf>



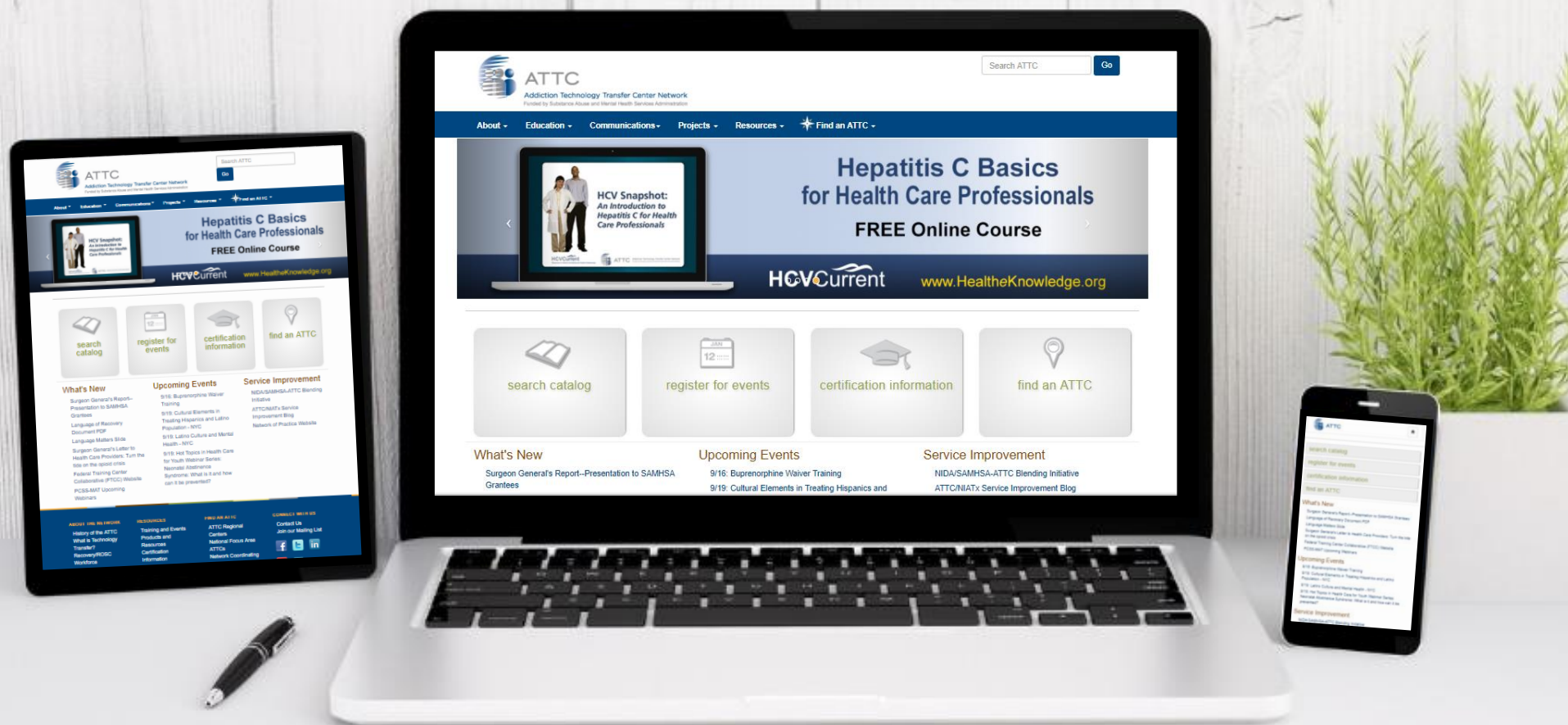
NM Hub Model

<http://newmexico.networkofcare.org/mh/content.aspx?cid=4229>



NM OPIOID HUB
Harm Reduction
Prevention
Treatment
Recovery

Learn more at **ATTCNetwork.org**



Roundtable Discussions (45 minutes)

Attendees will participate in facilitated small group discussions on substance use priority areas:

- **Prevention** (client education about SUDs and potential harm)
- **Screening/Early Identification**
- **Treatment and recovery** (use of medications, behavioral health treatment, recovery support services)
- **Overdose Prevention** (use of Narcan, medication management and education)

Team Time: Workplan Development (45 minutes)

Meet with your teams to reflect on how your PBHCl program addresses these areas and come up with an action plan for moving forward.